KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
Office of Local and Rural Health
Charitable Health Care Provider Program

ANNUAL REPORTING FORM

Form E

Point of Entry or
Provider Name_____

Location, Street Address:_____

City, State and Zip code_____

County_____

☐ 1. No activity to report (skip all others 2-4)

☐ 2. Total number of patients meeting medical indigency criteria

☐ 3. Total number of patients receiving SRS medical assistance (if applicable)

☐ 4. Total number of unduplicated patients (if available)

☐ 5. Total Charitable visits for _____
Year

Annual Reports are due by JANUARY 30 for the previous calendar year

March 6, 2002